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ABSTRACT

Constructivist approaches to therapy that view the therapist and patient as equal participants in co-creating a new dialogue render aspects of experience invisible. What is missing is an awareness of the dominant structures in society and the dominant ways of thinking and speaking. Three key factors need to be understood: first, the way meanings are embedded in language; second, the hierarchical nature of relationships, including the therapeutic relationship; and third, the larger social context in which therapy as an institution exists. Therapy is a cultural practice of modern European-related society, which reproduces that society's gender, class, and race systems. One way a therapist can question the dominant discourses and the ways patients may be harmed by them is by use of discourse analysis. Marital conflict is analyzed using three discourses of heterosexuality: (1) the permissive discourse; (2) the male sexual drive discourse; and (3) the marriage between equals discourse. Each discourse involves reciprocal patterns for men and women, but each also favors masculine interests and needs. The case illustrates how the therapist can bring marginalized views into the therapy room and make visible the cultural narratives through which we live. Contains 27 references. (Author)

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Reflections on the Invisible: The Missing Social Context in Therapy

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Abstract

Constructivist approaches to therapy that view the therapist and patient as equal participants in co-creating a new dialogue render aspects of experience invisible. What is missing is an awareness of the dominant structures in society and the dominant ways of thinking and speaking. Three key factors need to be understood: first, the way meanings are embedded in language; second, the hierarchical nature of relationships, including the therapeutic relationship; and third, the larger social context in which therapy as an institution exists.

Therapy is a cultural practice of modern European-related society, which reproduces that society's gender, class, and race systems. One way a therapist can question the dominant discourses and the ways patients may be harmed by them is by use of discourse analysis. I analyze a case of marital conflict using three discourses of heterosexuality--the permissive discourse, the male sexual drive discourse, and the marriage between equals discourse. Each discourse involves reciprocal patterns for men and women, but each also favors masculine interests and needs. The case illustrates how the therapist can bring marginalized views into the therapy room and make visible the cultural narratives through which we live.

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Reflections on the Invisible: The Missing Social Context in Therapy

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Reflections on the Invisible: The Missing Social Context in Therapy

Rachel T. Hare-Mustin

Constructivist approaches to therapy rest on the idea that the therapist and patient are engaged in a process of co-creating new meaning as equal partners in a dialogue. Many contemporary theories of knowledge and justice also assert that knowledge and justice are a matter of conversation and social practice (Rorty, 1979). I suggest that embracing this idea can lead to a form of constructivism that renders aspects of experience invisible. It disregards three key factors: first, the way meanings are embedded in language; second, the hierarchichal nature of relationships, including the therapeutic relationship; and third, the larger social context in which therapy as an institution exists.

It may seem heavy-handed to press these distinctions. I am doing so because I think we are missing a critical portion of experience. Of course, as a woman--and I have been a woman for some time--I have a particular view of the world. I have done my share of housework. I have also buried a lot of ironing in the back yard. My experience derives from being a white, European-American, middle class professional who has lived in a modernist era. I have circled the globe several times and lived and worked in Africa and Asia. I have been a professor at Harvard and other distinguished universities.

I am aware that I am in the awkward position of "criticizing the oppressive structures of society and benefiting from them at

the same time" (Prilleltensky & Gonick, 1994, p. 145). When I deconstruct my own world view, I see it as one of many ways of making meaning in the world. Of course feminist postmodern theory is not an unbiased approach. It is an oppositional stance to the ideology of patriarchy. Ideologies are complex: Like sand at the beach, they get into everything. Any oppositional critique will be deflected and devalued to maintain the status quo. What is important about a feminist postmodern approach is how, by destabilizing the plausibility of some kinds of explanation, it allows us a fuller version of what might be.

In a postmodern era there is no consensus, even among postmodern feminist theorists. Postmodernism is often described as a reaction to modernism's belief in truth, progess, and individuality, a decentering of European dominance and technology. For some feminists the postmodern era is a struggle about meanings and issues of language, power, and social regulation (cf. Bohan, 1993; Crawford & Marecek, 1989). Others see postmodernism as a rising of the margins against the center. For still others, postmodernism seems like a hankering for premodernism's dark romantic urges, with emphasis on community and family rather than individual identity, causality as circular rather than linear, a fascination with reflexivity, a preoccupation with language and thinking about thinking.

Therapy and Ideology

Therapy needs to be understood as one more cultural activity of modern European-related society, a social practice that reproduces the oppressive practices of society, such as the gender, class, and race systems. Indeed, therapy has been described by

Philip Cushman (1990) as inflicting on patients the same dominant discourses by which they have previously been harmed. In the therapy room our cultural heritage is typically treated as what is natural, rather than a particular system of deeply held values, localized in this time and place. The efforts of most therapists represent the interests and moral standards of the dominant groups in society (e.g. maintain the family, avoid divorce, keep the children in school). Certain premises of therapy--that the examined life is the better life, that change is better than continuity--are rarely questioned.

Constructivism needs to address the recursive nature of language. One aspect of meaning is that we not only use language, it uses us. Language provides the categories in which we think. Can we construct any reality? No. As Culler (1982) notes, one does not have a free play of meaning. Certain meanings are "authorized" in our society and others are ignored, discredited, and marginalized.

A further problem I see with constructivism is its inability to provide an adequate framework to address the dimension of power. Whose accounts are authorized and supported and whose marginalized and subjugated? Why are certain memories selected and others cast aside in therapy? In this regard the focus of constructivist therapists like Anderson & Goolishian (1988) differs little from that of Carl Rogers in selecting and reflecting on the self to the exclusion of the larger social context. Indeed, we are always bumping against questionable legacies in therapy. Our love affair with the unknowable self is a legacy from Freud. Another modernist legacy we cling to is the belief that an individual's feelings and experiences are a source of Truth. A constructivst view easily

retreats into such a modernist belief in the individual's Essential Truth.

As a postmodernist I am uncomfortable with such latent essentialism. There is an unresolved tension between adhering to social construction theory on the one hand, and privileging individuals' accounts of social life on the other (cf. Brown, 1991; Hindemarsh, 1993). Furthermore, individual or relational approaches to therapy may encourage patients to feel differently about themselves, but they leave the structural conditions of society unknown and unchanged. This is what is meant by "the intrinsic blindness to the everyday." As Borges once said, We know the Koran was written by Arab people because it does not mention deserts and camels, which were taken for granted, and in a way, invisible to them (Pakman, 1995). I believe only when we recognize the social character of knowledge can we become aware of the politics of knowledge.

The Mirrored Room

I see the therapy room as a mirrored room that only reflects back what is voiced within it (Hare-Mustin, 1994). A therapist who is not attentive to the meanings and hierarchies embedded in language and culture will reflect only the dominant ideologies of the society. The subordinate voices and concerns of marginalized groups will remain invisible and outside the conversation. In this way therapists uncritically reinforce and perpetuate inequalities in the dominant discourses.

Discourse theory is one of an array of postmodern approaches to knowledge that ask how meaning is constructed. By discourse, I mean a system of statements and practices that share common values.

A discourse provides the words and ideas for thought and speech. It brings certain phenomena into sight and obscures other phenomena.

Discourse analysis looks at competing ways of giving meaning to the world. As Foucualt (1972) observed, dominant discourses support prevailing ways of thinking and being, other discourses contest these dominant meanings. Feminist theorists have been concerned about how the dominant values form and deform our understanding in characteristic ways (cf. Hollway, 1989). The therapist who is aware of discourse analysis can address the social context in which patients' experiences are embedded as well as question relationships within the larger sociopolitical context that often go unacknowledged and unexamined (Korin, 1994).

The Latin root for "discourse" is discurrere, which means "to run around." Thus, different and competing discourses circulate in the culture. Some have a privileged influence on us, and constrain the ways we think and act. Subordinate discourses, on the other hand, are marginalized, and even co-opted by the dominant discourses, so they lose their oppositional force. Discourses associated with groups on the margins of society are excluded from influence and often ridiculed. Therapy is always a political act. How can the therapist avoid being complicit in reproducing the dominant social order?

A Case of What Is Truth

Let me describe a case to show how discourse analysis can be used in therapy to move beyond the confines of the mirrored room. Since gender is one of the most powerful stories that informs our experience I will examine three dominant discourses of heterosexuality. They are the male sexual drive discourse, the

permissive discourse, and the marriage between equals discourse. As Wendy Hollway (1984) has pointed out, such discourses define what is expected of men and women in relation to each other and produce feminine and masculine identities. Although these discourses involve reciprocal patterns for men and women it does not follow that men and women benefit equally from them. In each case the dominant discourse favors masculine interests and needs. There are of course other discourses of gender. In the United States we privilege a discourse of heterosexual relations, obscure a discourse of female desire, and promote a discourse of female victimization (Fine, 1988).

In this illustrative case the husband and wife are caught in a bitter long-running dispute. She claims he was having sex with another women. He says she is crazy. So they argue in therapy. As Smith (1991) describes the case, the wife arrives home unexpectedly from work and finds the front door locked, which is unusual. Her husband answers the door, undressed except for a pair of jeans. His brother's woman friend emerges partially dressed from the bathroom straightening her clothes. The bed sheets are rumpled and stained with semen. The husband is vehement in his denial that anything improper has taken place, saying that he had an erotic dream, ejaculated, and then his brother's woman friend stopped by on an errand.

A therapist could readily take a neutral stance, what we foolishly call "value free," not supporting either story while the wife became more agitated in the face of her husband's denials. This would provide the customary evidence that women are emotionally over-reactive and give distorted versions of the truth

whereas men deal with facts. Or the therapist could even-handedly reaffirm the permissive discourse of sexual freedom for each of them.

In contrast, a therapist aware of how the dominant discourses privilege male interests might look beyond what is presented in the mirrored room to issues of gender inequality, hierarchy, and power. Such a therapist would recognize that the permissive discourse, while giving both sexes the right to express freely their sexuality, has a different effect on men and women. For men, permissiveness can mean open sexual access; for women, permissiveness can mean pressure to accede to men's urging for free sexual activity. Moreover, within the permissive discourse, women are made to think they have no right to feel betrayed by male infidelity because women are theoretically allowed the same liberties. The permissive discourse justifies men's sexual freedom while punishing women who object to it by denying the validity of their objections.

Power is eroticized by the male sexual drive discourse. This familiar discourse constructs men's sexual urges as natural and compelling and authorizes the male to be pushy and agressive in seeking to satisfy them. Women are viewed as the objects that inflame men's sexual urges. In combination, the permissive discourse and the male sex drive discourse further coerce women to meet men's desires by labeling reluctant women as uptight or teases who frustrate what is presumed to be men's basic nature.

What could the therapist offer as a counterplot or alternate narrative? How could a therapist aware of marginalized discourses of inequality deconstruct these stories (White, 1993)? What is the

therapist's responsibility for bringing in the unsaid? To ask such questions is not to impose the therapist's views on patients, but to recognize that the dominant discourse may not be in the patient's interest. The therapist asks how comfortable patients are with such discourses, how much they wish to change. For this couple the therapist needs to understand: How much is the wife influenced by the idea that "women are not listened to," which pushes her into anger (Zimmerman & Dickerson, 1993)? How much is the husband influenced by the idea that "a man has to prevail" or he is not a real man?

I would remind you that the male sexual drive discourse prescribes the characteristics and behaviors in our society associated with heterosexual men and male dominance. The man with little or no interest in trying to dominate women or compete with other men challenges the male sexual drive discourse. Allan Hunter (1992) has described his experience as what he calls a "sissy male." The sissy does not have an identity dependent on how <u>different</u> he is from women. Hunter admitted being concerned that sex would lose its sexiness without elements of the hunt, the chase, and the seduction. Being outside the dominant discourse can be risky and frightening for both men and women.

The pressures on men to conform to the conventional stereotypes of masculinity can be much more severe than those on women. Men oppress other men in the service of dominant ideologies, not just women (McLean, Carey, & White, 1996). Not all men are equal in a white macho world. As Bell Hooks (1987) asks, which men do women want to be equal to? The therapist needs to be aware of the sanctions for not meeting the masculine ideal, as well as the

rewards for achieving it. She asks each person: Where do your ideas about men and women come from? How do you feel about them? What does it mean to not meet those standards?

The therapeutic approach Smith (1991) described with the couple involved reframing the entire dispute as a comparison of good and bad storytellers rather than a debate over sexual freedom, truthfulness, or betrayal. The therapist asked both members of the couple to tell their stories about the event. The therapist remarked on the vagueness of the husband's story in contrast to the detail and vividness of the wife's story. The therapist asked them both to work on their stories. After several sessions the therapist asked the husband to tell the wife's story, but the husband argued that he could not do so because her story was not true and his was. Finally, the husband told the wife's story, and she was much relieved. The telling of stories allowed the couple to gain distance from the event and bring an end to their dispute. It also changed the idea that there was a "true story" or that one had to be "right," the other "wrong." The husband was offered an alternative story in a context of story-telling.

This case can be see as one where the wife had been told that what she saw was not "true," that she was crazy. The therapist recognized that the wife's experience was being denied. In the face of male authority, the wife is traditionally expected to give way. Without addressing the issue of truth, the therapist arranged a task that confirmed rather than denied the wife's experience, however much it might be at variance with the dominant discourses of sexuality.

Marriage in the United States reflects the problem of how to manage inequality in a society whose ideal is equality (Hare-Mustin, 1994). We all know that marriage and the family are much admired by people like Congressmen, who hardly ever see their families. Inequalities in marriage related to gender are traditionally regarded as unintentional and incidental. The dominant discourse regards men and women as "naturally" so different they cannot be compared (Hare-Mustin & Marecek, 1990; 1994). Both men and women participate in the discourse of marriage between equals and cooperate in concealing women's subordination and men's domination by reframing inequality as difference. Ideas of essential gender differences have been called "ruses" by Michael White because they disguise what is taking place; they obscure operations of power (cf. Tomm, 1993). Many therapists in the mirrored room seem unaware of how they are taken in by such ruses.

Conclusion

Discourse analysis opens up possibilities in therapy beyond a simple constructivist approach. It reminds us there is a predetermined content to therapy in the mirrored room, that provided by the dominant discourses. Who can speak and what can be said in therapy often go unacknowledged. When the range of discourses in the therapy room ignores the position of subordinate groups therapy becomes the pursuit of self-replicating images. In this way, therapy can be oppressive, not so much by what it includes, as what it excludes. As Waldegrave (1990) has observed, therapy enshrines patriarchal meanings, supporting rather than challenging hierarchies of gender, race, and class. The needs of those most disadvantaged remain invisible. Therapy should be a

matter of helping patients deconstruct not only self-narratives but dominant cultural narratives and discursive practices that constitute their lives (Laird, 1995).

If we disregard the influence of cultural narratives on our patients and ourselves, our therapy may not be worth doing. And as I have said elsewhere, therapy that is not worth doing is not worth doing well.

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